

## MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026507

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

6070

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUD

AMENDED

FILED JUN 21 1963

## 1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR  
TOWN ST. LOUIS, MISSOURI

Length of stay in 1b

Life

## 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

admission)

c. CITY

OR  
TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR  
INSTITUTION BARNES HOSPITAL

Inside Limits

Yes ☒ No ☐

d. STREET

ADDRESS

(If outside, give location)

4537a Arco Avenue

Reside on Farm

Yes ☐ No ☒

## 3. NAME OF DECEASED

(Type or print)

First

WALTER

Middle

F.

Last

WELFENBERG

4. DATE

OF  
DEATH

Month

June

Day

7

Year

1963

## 5. SEX

Male

## 6. COLOR OR RACE

White

7. Married ☒Widowed ☐

## 8. DATE OF BIRTH

11-7-1897

## 9. AGE (last birthday)

65

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired - Chiropractor

10b. KIND OF BUSINESS OR INDUSTRY

Medical Profession

11. BIRTHPLACE (City and state or country)

St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY

U.S.A.

## 13a. FATHER'S NAME

Robert C. Welfenberg

## 13b. MOTHER'S MAIDEN NAME

Caroline Barnkastle

## 14. NAME OF HUSBAND OR WIFE

Mary Foitag Welfenberg

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown)

No

## (If yes, give war or dates of service)

None

## 17. INFORMANT

Address

Mrs. Mary Welfenberg, 4537a Arco Avenue

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

Subarachnoid Hemorrhage

## INTERVAL BETWEEN

ONSET AND DEATH

5 days

Conditions, if any,  
which gave rise to  
above cause (a),  
stating the under-  
lying cause last.

## DUE TO (b)

Ruptured Aneurysm right anterior cerebral artery

## DUE TO (c)

330X

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

## PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

## 19. WAS AUTOPSY PERFORMED?

YES ☒ NO ☐

## 20a. ACCIDENT

☐

## SUICIDE

☐

## HOMICIDE

☐

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

## 20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐NOT WHILE AT WORK ☐

## 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 6/3/63

to 6/7/63

and last saw him alive on 6/7/63

Death occurred at 8:10 p.m.

m on the date stated above, and to the best of my knowledge, from the causes stated.

## 22a. SIGNATURE

(Degree or title)

FR. Bradley M.D.

Frank R. Bradley M.D.

## 22b. ADDRESS

BARNES HOSPITAL

## 22c. DATE SIGNED

6/8/63

## 23a. BURIAL, CREMATION, REMOVAL (Specify)

Removal

## 23b. DATE

6-12-1963

## 23c. NAME OF CEMETERY OR CREMATORY

Oak Grove Cemetery

## 23d. LOCATION (City, town, or county)

St. Louis, Co., Mo.

## (State)

## 24. FUNERAL DIRECTOR

ADDRESS

CALVIN F. FEUTZ, 4828 Natural Bridge Bl.

## 25. DATE RECD. BY LOCAL REG.

JUN 10 1963

## 26. REGISTRAR'S SIGNATURE

Road Smith M.D.

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*John A. Martin*

Licensed Embalmer No. 4186

P. O. Address St. Louis, Mo.

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.